Reigning in the Rising Cost of Health Care: Policy Recommendations to Congress and the Administration

October 2004

A Report by the Health Care Cost Containment Task Force

3rd Congressional District of Pennsylvania

Assembled by Congressman Phil English

Reigning In the Rising Cost of Health Care: Policy Recommendations to Congress and the Administration

October 2004

Health Care Cost Containment Task Force Members

Charlie Anderson
President/CEO
Meadville-W. Crawford County Chamber of Commerce

Dr. Tony Bilott

Jeff Byham
Byham Insurance Services

Chester P. Chrzanowski

John Dundon
Yellow Cab

Jim Gallagher
President
UAW Local 3303

Ronald W. Gibbs
Secretary Treasurer, Business Agent
Teamsters Local 397

Jack Hoard
Armstrong Memorial Hospital

Stanley Kosciuszko
Butler County Chamber of Commerce

Murray S. Marsh, Jr. CHE
Chief Financial Officer
Warren General Hospital

Patricia Marshall
Gannon University Nursing Department

Mike Martin
Printing Concepts

William R. McWhirter, M.D.
President
Northwest Orthopedic Associates, P.C.

Dr. Gary Pasqualicchio

Don Pavlek
Chief Executive Officer
Corry Micronics, Inc.

Raymond W. Schauer
Vice President for Finance
Sharon Regional Health System

Pete Sitter
St. Vincent Hospital

Kenneth C. Venmar
Vice President, Kerven Subaru

Table of Contents

Introduction:

In an effort to reign-in escalating healthcare costs, Congressman English (PA-3) convened the Health Care Cost Containment Task Force (HCCCTF). This task force was comprised of local business leaders, labor unions and healthcare organizations and was charged with identifying the causes of rising healthcare costs and how to best address them. This report contains their recommendations.

General Findings:

Spending on health care is increasing at the fastest rate in a decade, reflecting greater use of hospitals and prescription drugs and the declining influence of managed care. In 2001, health spending rose 8.7% to $1.4 trillion, or 14.1% of the total economy – the largest share on record at $5,035 per person in the United States. The impact of such rapidly rising health care costs is exacerbated by the state budget crises for states and soft market conditions for private companies.

Prescription drugs are the fastest rising cost segment of the health care industry: The nation spent $140.6 billion on such medicines in 2001, up 15.7 percent from the prior year. In 2001, for the first time, spending on prescription drugs exceeded spending on nursing homes and home health care combined.

Medicare and Medicaid costs are also rapidly rising. Medicare spending, for the elderly and disabled, rose 7.8% in 2001, while spending under Medicaid, the federal-state program for low-income people, soared 10.8%. Outside of Medicare, health insurance premiums increased an average of 11% in 2001 and are expected to rise an additional 13% this year. Employers are beginning to pass on those higher costs to their workers, in the form of higher co-payments, deductibles and contributions to premium. According to the Kaiser Foundation, the amounts employees pay for deductibles in typical health plans rose by more than 30% in 2002 from 2001 after little or no growth in recent years.

Recommendations:

I. Focus on Prevention

Anti-Smoking Education in Schools

Findings

- Pennsylvania has an adult smoking rate of 24.6%, a pregnant smoking rate of 16.7%, a youth smoking rate of 27.6% with 36,400 new youth smokers each year, and 19,700 adult deaths from smoking annually.[1]
- Each day, nearly 6,000 children under 18 years of age start smoking; of these, nearly 2,000 will become regular smokers. That is almost 800,000 annually; it is estimated that at least 4.5 million U.S. adolescents are cigarette smokers; and approximately 90 percent of smokers begin smoking before the age of 18.[2]
- Tobacco related health costs in Pennsylvania in 1998 reached $4 billion; smoking caused productivity losses reached $3.94 billion; Pennsylvania taxpayers are saddled with a $2.72 billion burden as a result of tobacco use; and the average household in Pennsylvania incurred a tax burden of $560 per year as a result of federal and state smoking caused expenditures.[3]
- If current tobacco use patterns persist, an estimated 6.4 million children will die prematurely from a smoking-related disease.
- According to a 2001 national survey of high school students, the overall prevalence of current cigarette use was 28 percent.
- Nearly 20 percent of 12th graders, 12 percent of 10th graders and 5.5 percent of 8th graders smoke cigarettes daily.
- Adolescents who smoke regularly can have just as hard a time quitting as long-time smokers.
- Of adolescents who have smoked at least 100 cigarettes in their lifetime, most of them report that they would like to quit, but are not able to do so.

Recommendations

- Forbid smoking by students, staff and visitors on all school grounds and at all school-sponsored events.
- Provide necessary government funding to mandate comprehensive tobacco prevention education similar to the plan prescribed by the Campaign for Tobacco-Free Kids:[4]
    - Programs should not focus on only one aspect of smoking, such as the short and long-term negative health effects but should also address social acceptability, social influences, negative social consequences from tobacco use, peer norms and peer pressure, resistance and refusal skills, and media literacy as it relates to tobacco marketing and advertising.
    - In addition, it is not enough to offer anti-smoking education only in middle school or early high school. Students should receive this instruction and guidance, in one form or another, throughout their educational experience.
- Provide program-specific training for teachers.
- Involve parents and families in school efforts to prevent tobacco use.
- Help tobacco-using students and staff quit.
- Evaluate school tobacco prevention programs at regular intervals.

Nutrition Education Programs / Combating Obesity

Findings

- During the past 20 years there has been a dramatic increase in obesity in the United States.
- In 1991, four states were reporting obesity prevalence rates of 15–19 percent and no states reported rates at or above 20 percent.[5]
- In 2002, 18 states have obesity prevalence rates of 15–19 percent; 29 states have rates of 20–24

percent; and 3 states have rates over 25 percent.[6]

- The prevalence of overweight among youth ages 6-17 years in the United States has more than doubled in the past 30 years; most of the increase has occurred since the late 1970s.[7]
- Unhealthy eating practices that contribute to chronic disease are established early in life; young persons having unhealthy eating habits tend to maintain these habits as they age.[8]
- In 2000, the total cost of obesity was estimated to be $117 billion. Of this amount, $61 billion was due to direct medical costs and $56 billion to lost productivity.[9]

Recommendations

- Develop comprehensive school health programs that include health education; a healthy environment; health services; counseling, psychological and social services; integrated school and community efforts; physical education; nutrition services; and a school-based health program for faculty and staff.
    - For example schools could provide:[10]
        - Appealing, low fat, low sodium foods in vending machines and at school meetings and events;
        - School counselors and nurses providing guidance on health and, if necessary, referrals for nutritional problems;
        - Community organizations providing guidance or nutrition education campaigns;
        - Physical education instructors helping students understand the relationship between nutrition and physical activity;
        - School food service personnel serving healthy, well balanced meals in the cafeteria; and
        - School personnel acting as role models for healthy eating.
    - Additionally, this Task Force endorses the methodology of the CDC on implementing community education plans:[11]
        - Policy: Adopt a coordinated school nutrition policy that promotes healthy eating through classroom lessons and a supportive school environment.
        - Curriculum for nutrition education: Implement nutrition education from preschool through secondary school as a part of a sequential, comprehensive school health education curriculum designed to help students adopt healthy eating behaviors.
        - Instruction for students: Provide nutrition education through developmentally appropriate, culturally relevant, fun, participatory activities that involve social learning strategies.
        - Integration of school food service and nutrition education: Coordinate school food service with nutrition education and with other components of the comprehensive school health program to reinforce messages on healthy eating.
        - Training for school staff: Provide staff involved in nutrition education with adequate pre-service and ongoing in-service training that focuses on teaching strategies for behavioral change.
        - Family and community involvement: Involve family members and the community in supporting and reinforcing nutrition education.
        - Program evaluation: Regularly evaluate the effectiveness of the school health program in promoting healthy eating and change the program as appropriate to increase its effectiveness.

<u>Chronic Disease Management / Workplace Wellness Programs</u>

Findings

- More than 1.7 million Americans die of a chronic disease each year, accounting for about 70% of all

U.S. deaths. 5 chronic diseases (heart disease, cancer, stroke, chronic obstructive pulmonary disease and diabetes) cause more than two thirds of all deaths each year.[12]

- Chronic disease accounts for roughly 75% of health care costs each year and chronic disease risk factors also place huge economic demands on our nation.[13]
- In 2003, the estimated cost of cardiovascular disease was $117 billion; in 2002, the estimated cost of cancer was $171.6 billion; in 2002 the estimated cost of diabetes was $132 billion; the estimated cost of arthritis in 1995 was $82 billion; health care costs associated with physical inactivity were estimated at more than $76 billion in 2000; and each year, over $33 billion in medical costs and $9 billion in lost productivity are attributed to poor nutrition.[14]
- Although chronic diseases are among the most common and costly of all health problems, they are also among the most preventable.
- Regular screening for colorectal cancer can reduce the number of people who die of this disease by at least 30%; regular mammograms can dramatically reduce a woman's risk of dying from breast cancer by about 16% for women aged 40 years or older.[15]
- Substantial disparities exist among race, ethnicity and socioeconomic status. For example:
    - In 1999, death rates from heart disease were 29% higher and death rates from stroke were 40% higher among African American adults than among white adults.
    - American Indians and Alaska Natives are 2.6 times more likely, African Americans are 2 times more likely, and Hispanics are 1.9 times more likely to have been diagnosed with diabetes than whites.
- Wellness programs at the workplace are an exceptional method of continuing nutritional and physical activity education following secondary school.
- Employers such as Lincoln Plating have achieved dramatic results in increasing employee health and reducing the cost of caring for employee health.
    - For example, Lincoln Plating has achieved annual costs per employee that are: 84% versus the region; 80% versus employer size; and 86% versus industry.
    - During the period of December – June 2002, participating employees in Lincoln Plating's wellness program achieved major gains in health:
        - Systolic blood pressure down 11.4%
        - Diastolic blood pressure down 15.7%
        - Cholesterol down 7.4%
        - Body mass index down 0.6%

Recommendations

- Incentivize, through tax deductions, the creation of wellness programs such as the one at Lincoln Plating that include:
    - Pre-assessment – personal wellness profile (physical assessment, blood profile, and health risk/assessment questionnaire).
    - Individual wellness plans
    - Scheduled wellness events
    - Post-assessment (repeat of pre-assessment)
    - Major scheduled wellness event
- Advance policies that promote healthy environments
    - Continued funding for programs that develop safe walking and cycling trails, such as the Rails-to-Trails program.
    - Smoke-free policies in the workplace and public areas.
- Ensure access to a full range of quality health services
    - Improved access to effective screening and diagnostic tools for breast, cervical and colorectal cancers; diabetes; high blood pressure; and high cholesterol.
    - Better training and education of health care providers to close the gap in time between discovering effective prevention tools and strategies and applying these tools in medical practice.

    - Public and private health insurance programs that provide appropriate chronic disease prevention, screening and treatment services.
    - Training to empower patients to manage their chronic conditions effectively.
- Implement programs that focus on eliminating racial, ethnic and socioeconomic-based health disparities.
    - Prevention research is needed to identify the causes of health disparities and the best ways to provide access to high-quality preventive care and clinical services.
- Market health, healthy lifestyles and nutrition effectively.

Medical Errors

Findings

- In 1999, The Institute of Medicine (IOM) reported that preventable medical errors are the eighth leading cause of death in America – ahead of breast cancer, AIDS and traffic deaths; nearly 100,000 patients die in hospitals each year as a result of preventable mistakes.[16]
- In its study, the IOM studied the prevalence and methods of eliminating medical errors. Four main conclusions were reached:[17]
    - The elimination of medical errors will not be accomplished by attempting to identify and discipline the "bad apples". The IOM report concluded that errors are not solely the fault of individual doctors, nurses, and other clinicians; they are often "a failure in the process of delivering care in a complex delivery system."
    - If a patient experiences an adverse event during the process of care, this does not necessarily mean that a medical error has occurred.
    - Much can be learned from the analysis of errors, including errors that result in little or no injury to the patient. This, the IOM found, was a result of aggregating the data to identify relevant patterns of system failures.
    - Health care providers need to be assured that if they report errors that are necessary to detect system problems, these reports will be used for that purpose in a culture of safety rather than unproductively as grist for the litigation mill.
- The HealthGrades Patient Safety in American Hospitals study, released July 2004, provides an updated look at medical errors and is the first such study to look at the mortality and economic impact of medical errors and injuries that occurred during Medicare hospital admissions nationwide from 2000 to 2002.
- The HealthGrades study finds nearly double the number of deaths from medical errors found by the 1999 IOM report "To Err is Human," with an associated cost of $6 billion per year.[18]
- The data in the HealthGrades report, if extrapolated to the entire U.S., conclude an extra $19 billion was spent and more than 575,000 preventable deaths occurred from 2000 to 2002.[19]

Recommendations

- Embrace reforms included in H.R. 877, *The Patient Safety Improvement Act of 2003*, introduced by Representative Nancy Johnson, including:
    - Extend confidentiality protection and privilege standards to patient safety data that are reported externally to new Patient Safety Organizations (PSO).
    - Direct the PSOs to analyze the reports from health care providers and provide feedback on what went wrong and how to fix it; report adverse events and close calls in order to gain insight into how to prevent errors.
    - Create a new Center for Patient Safety within the U.S. Department of Health and Human Services to be the focal point of Administration policy on patient safety. This center would administer a new medical errors database on non-identifiable information that researchers will use to identify national trends and encourage best practices to prevent errors and improve health care quality.
    - Establish a process through which new, voluntary standards for interoperability can be

developed.

II. Prescription Drugs

Reimportation of Pharmaceuticals into the United States

Findings

- A survey of prescription drug prices on five widely-prescribed drugs revealed that consumers could save, on average, 49.5 percent by purchasing their drugs in Canada. For example, Zyrtec 10 mg (per pill) cost $1.92 in Erie, PA and only $.85 in Canada; Synthroid 100 mg cost $.48 in Erie and only $.16 in Canada; Fosamax 70 mg cost $16.35 in Erie and $11.00 in Canada; Plavix 75 mg cost $3.98 in Erie and $2.45 in Canada; Vioxx 25 mg cost $2.77 in Erie and $1.26 in Canada.
- The Food and Drug Administration (FDA) currently regulates the domestic market for pharmaceuticals, but has no authority in foreign markets.
- FDA Associate Commissioner for Policy and Planning, William Hubbard, has stated that the FDA currently has seen its number of counterfeit drug investigations increase four-fold since the late 1990s.[20]
- A review conducted by Giuliani Partners at the John F. Kennedy International Airport Mail Facility in New York, New York found that of approximately 40,000 packages per day suspected to contain drugs, only about 500 to 700 are inspected. The drugs in those inspected packages come from around the world, and many were not FDA approved; some were past their expiration dates or inappropriately packaged.[21]
- An American Association of Retired Persons (AARP) study found that "prices for those brand name prescription drugs most frequently used by older Americans and available in January 2000 increased, on average, a cumulative 27.6 percent over the four year period 2000 to 2003 as compared to a general inflation rate of 10.4 percent.[22]

Recommendations

- The reimportation ban should be lifted; starting with Canada and the European Union and moving onto other countries on a case by case basis.
- The Office of the U.S. Trade Representative should seek to include and/or expand in every bilateral, multilateral and regional trade agreement free trade principles in regard to restrictions on compulsory licensing.
- The Secretary of Health and Human Services should establish a method by which drugs entering the U.S. through reimportation are adequately safe and legitimate.
- Adequately regulate Internet sales of pharmaceuticals.

Direct-to-Consumer Advertising

Findings

- A recent survey reported that Direct-to-Consumer (DTC) advertising encouraged more than 24 million consumers to discuss medical conditions with their doctors, conditions they had never mentioned to physicians before seeing the advertisement.[23]
- More recent studies by the Food and Drug Administration are now available which, when compared, reveal that awareness of DTC ads is increasing. For example, 81 percent of respondents in 2002 reported seeing or hearing an ad for a prescription drug. This figure is up from 72 percent in 1999.[24]
- 58 percent of those surveyed also strongly agreed that DTC ads make the drugs seem better than they really are.[25]
- About 75 percent of physicians believed that DTC ads cause patients to think that the drug works better than it does, and many physicians felt some pressure to prescribe something when patients mentioned DTC ads.[26]

- Eight percent of physicians said they felt they felt very pressured to prescribe the specific brand name drug when asked.[27]

Recommendations

- DTC advertising should be banned on all forms of media.
- Advertising and product awareness should only occur between physicians and drug companies.
- Patients should only receive information about relevant prescription drugs through their physician and the physician should have the ability to discuss alternative treatments and generic mediations with their patients without the patient potentially being influenced as a result of DTC advertising.

Prescription Drug Price Negotiation / Bulk Purchasing

Findings

- The number of enrollees in each of the three largest pharmaceutical benefit managers (PBM) far exceeds the current 41 million Medicare enrollees.[28]
- About 70 PBMs manage nearly 80 percent of all expenditures on prescription drugs in the United States. About 70 percent of all patients whose plans utilize PBMs are enrollees in health plans under contract with one of the five largest PBMs.[29]
- PriceWaterhouseCoopers (PwC) estimates that, on average, pharmacy benefit management reduces prescription drug costs by 25 percent compared to retail purchases with no pharmacy benefit management support.[30]
- Pharmacy benefit management activities in 2004 will reduce costs by $268 per enrollee in private plans, or about $53 billion total.[31]
- PwC estimates that total savings from pharmacy management over the next ten years, 2005-2014, will amount to about $1.3 trillion.[32]
- PBMs achieve these savings through a variety of tools: electronic claims processing, formulary development and management, networks of pharmacies, generic substitution, rebates and discounts, therapeutic interchange, mail-service pharmacy option, drug utilization review, disease management, consumer information, and consumer compliance programs.
- PwC estimates that prescription drug spending managed by private, third party payers (almost universally employing PBMs) will account for 68 percent of prescription drug spending in 2005, or about $158 billion. The proportion managed by PBMs will jump to 84 percent when most Medicare beneficiaries enroll in private, prescription drug plans under MMA.[33]
- Total savings are estimated to be $53 billion in 2005, rising to $88 billion when most Medicare beneficiaries are brought under PBM arrangements in 2006, and reaching $194 billion in 2014, for a total over the next decade of $1.3 trillion in savings.[34]
- On a per beneficiary basis, these savings translate into a reduction in drug costs per beneficiary of $268 for those enrolled in private health plans in 2005 and – because Medicare beneficiaries use more prescription drugs – about $937 per Medicare beneficiary in private plans in 2005.[35]

Recommendations

- PBMs should continue to be utilized wherever possible in order to extract substantial savings on prescription drugs for health plan enrollees through negotiation and purchasing arrangements.
- Efforts should be made on the state and federal levels to ensure that the tools which PBMs utilize to provide savings on prescription drugs are not limited. For example, efforts to: limit therapeutic interchange, limit other drug management techniques, limit mail-service pharmacies, require PBMs to disclose contract terms, or require PBMs to bear fiduciary responsibility should be resisted.
- The federal government should continue to defend states' rights to enter into collective agreements for the purposes of purchasing health care products and prescription drugs for Medicaid enrollees and support the efforts of states to enter into such agreements. For example, on April 22, 2004, Secretary Thompson approved plans by five states to pool their collective purchasing power to gain deeper discounts on prescription medicines for their state Medicaid programs.[36]

Speeding Generic Pharmaceuticals to Market

Findings

- The use of generic drugs almost doubled from about 20 percent to 40 percent of prescriptions during the period 1985-2001; the Congressional Budget Office estimates that this trend has saved consumers between $8 billion and $10 billion per year.[37]
- In 1990, the average cost per prescription for brand name medications was $27.16, while the average cost for generic drugs was $10.29. By 2000, the average cost per prescription reached $65.29, while the generic increased to only $19.33.[38]

Recommendations

- Continued refinements should be made to Hatch-Waxman, such as those made in MMA, to achieve the two fundamental components relating to generic pharmaceuticals: making lower-cost generic copies of approved drugs more widely available, while granting extended patent protection to developers of new drugs to ensure adequate incentives to innovate.

III. Insurance Model Changes

Medical Malpractice

Findings

- The median medical liability award in medical liability cases jumped 114% from 1996 to 2002, topping $1 million; the average award reached $3.9 million in 2001, and increased to $6.2 million in 2002.[39]
- Overall, nearly 70% of medical liability claims in 2002 were closed without payment to the plaintiff; plaintiffs lost the majority of their cases that went to a jury: of the 7% of claims that went to jury verdict, the defendant won 82.4% of the time.[40]
- Defense claims averaged $91,803 per claim in cases where the defendant prevailed at trial; in cases when the claim was dropped or dismissed, costs to defendants averaged almost $16,160.[41]
- Pennsylvania's largest medical liability insurer, the Phico Group, has been placed in liquidation and the MIIX Group and Princeton Insurance have ceased writing new policies in Pennsylvania.
- 45% of hospitals reported that the professional liability crisis has resulted in the loss of physicians and/or reduced coverage in emergency departments.[42]
- Difficulty obtaining medical liability insurance caused Abington Memorial Hospital outside of Philadelphia to close its trauma center for almost two weeks.
- At Penn-State-Hershey, doctors are employees of the medical center, which pays for their insurance. It expects to pay $30 million for malpractice coverage this year, up from $4 million in 1997.[43]
- The U.S. Department of Health and Human Services released a report on March 3, 2003 concluding that costs borne by the federal government would be reduced by up to $50.6 billion per year were reasonable limits on non-economic damages enacted.[44]
- More than two out of three medical residents in six medical specialties chose to leave Pennsylvania after completing their training; the greatest drain of medical school graduates were those entering high-risk specialties: Ob-Gyns, orthopedic surgeons and neurosurgeons.[45]
- According to Grand View Hospital President Stuart Fine, the medical liability crisis is a main reason why patient access problems are occurring throughout the state and has caused experienced doctors to leave the area, especially neurosurgeons, orthopedic and general surgeons, ob-gyns. Few young doctors are coming to take their place, and the result is a shortage of doctors.[46]
- Physicians are leaving Pennsylvania because of skyrocketing medical liability insurance rates and the out-of-control legal climate: General surgeons practicing have declined from 1,600 to just over 1,000 (1997-2002) orthopedic surgeons have dropped from 890 to 745 (1997-2002); neurosurgeons have dropped from 215 to 180 (1995-2002).[47]
- The amounts that physicians pay for malpractice coverage are generally based on broad aggregates,

which reflect factors such as doctors' medical specialties and locations but neglect relevant differences in the quality of their services.[48]

Recommendations

- The United States Congress should pass a national medical malpractice reform bill to cap non-economic damages.
- A "bad doctor" database should be compiled and maintained. The purpose of this database would be three-fold: to educate patients on the past level of quality provided by a specific physician or facility, to allow insurance companies to better track varying levels of quality each provider offers – and base rates on the level of quality rather than aggregate levels based on arbitrary geographic factors, and to incentivize increased quality of care from all providers.
- Institute changes in state insurance law and regulation which would allow insurance companies to change medical liability insurance rates based on a sliding scale: doctors with higher, legitimate claims or settlements should pay higher premiums than doctors with no or few claims or settlements.

Health Savings Accounts

Findings

- In 2002, 43.6 million Americans went without health insurance at some point. Most were uninsured for a short period: 44.1 percent for less than four months and an additional 19.9 percent for between five and 8 months.[49]
- Almost half of America's uninsured workers are either self-employed or in firms with fewer that 25 workers; Over 30 percent of workers in small firms lack insurance.[50]
- Current tax law provides an advantage for the purchase of health insurance for those who get that insurance through their employer, but this favorable tax treatment is not available for people who purchase health insurance on their own in the individual market.
- In 2004, there will be an estimated $188.5 billion tax break for individuals and families with employer provided health insurance, with 26.7 percent of that tax benefit going to families with incomes of $100,000 of more – roughly 14 percent of 14 percent of the population. Families with lower incomes see less of a benefit.[51]
- Since HSAs became available on January 1, 2004, individuals and families of all sizes have chose to enroll in them: of the enrollees, 38 percent were individuals, 16 percent were individuals and their spouses, and 4 percent were individuals with one child; families of varying size make up the remaining 42 percent.[52]
- 250 million nonelderly Americans now have access to HSAs.[53]

Recommendations

- HSAs should be retained and expanded as they are the best vehicle to contain health care costs and channel medical spending to areas which patients and their doctors really think is best.
- Along with the increased use of HSAs, a new and comprehensive database measuring cost and quality must become readily available to consumers. As HSAs, in conjunction with a high-deductible health insurance policy, give individuals and their doctors an incentive to avoid wasteful health spending, patients will need easily accessible, reliable information that they can base their health care spending choices on.
- As HSAs become more prevalent, federal resources should be channeled to families for health insurance coverage based on need.
- Steps should be taken by Congress to ensure that available choices of health insurance should not depend on the place of employment. In other words, employers should be able to contribute to an employee's HSA and employees should then be able to enroll in any plan offered in their area with those HSA dollars; in this manner, small business employees would not have to rely on their employer offering an insurance program to access "employer-sponsored" coverage.

- Likewise, small employers which choose not to administer health insurance plans should continue to sign up workers for coverage in the workplace and obtain tax subsidies through the workplace. This will ease the individual's administrative burden and reduce the initial barriers to locating individual market coverage in conjunction with an HSA.
- In order to increase coverage for employees of small firms, Congress should consider: Creating a refundable tax credit for workers in small firms in order to eliminate the bias against employees choosing their own coverage and to subsidize those who need the most help; and create alternative pools for the employees of small firms – including plans offered through churches, unions, and other intermediaries – so that these workers and their families can access a wide range of affordable plans.[54]

Association Health Plans

Findings

- According to a recent survey sponsored by the Kaiser Family Foundation and conducted by the Health Research Educational Trust, only 55 percent of companies with 3 to 9 employees offer coverage, compared to 74 percent of those with 10 to 24 workers, 88 percent of firms with 25 to 49 workers, and 99 percent of firms exceeding 200 workers.[55]
- "High premiums" are the reason cited by 68 percent of all companies with fewer than 200 employees that do not offer coverage.[56]
- AHPs already exist, although different states impose different types of regulations on them. If AHPs became certified under federal law, the added complexity of complying with 50 separate state regulations – a major obstacle and source of cost for small businesses which provide insurance – would be eliminated.
- AHPs offer a number of advantages which decrease cost and increase quality through: marketing efficiencies, increased choice for employees, reduced administrative costs, consistent regulations, and fewer mandated benefits.

Recommendations

- AHPs should be enacted on a federal level, thus allowing AHPs to become an effective tool for small businesses to provide health insurance coverage for their employees.
- Strong oversight of AHPs should be within the purview of the United States Department of Labor.

Catastrophic Claims

Findings

- Catastrophic claims are both high cost and unpredictable and raise the cost of insurance for everyone.

Recommendations

- Create a government catastrophic fund to pay claims over a certain amount; the fund would be established and sustained through payroll surcharges on employers and employees.
- The catastrophic fund would reimburse insurers, or employers if the employer self-insures, the full cost of costs over the catastrophic trigger amount.
- Insurers and self-insuring employers would be required to pass along savings as a result of the government sponsored catastrophic fund to their beneficiaries or employees.

(Endnotes)

[1] U.S. Centers for Disease Control and Prevention (CDC), *State Highlights 2002: Impact and Opportunity*, April 2002, www.cdc.gov/tobacco/StateHighlights.htm.
[2] Ibid.
[3] Ibid.
[4] National Center for Tobacco-Free Kids, *How Schools Can Help Kids Stay Tobacco-Free*, January 2004, http://tobaccofreekids.org/research/factsheets/pdf/0153.pdf.
[5] U.S. Department of Health and Human Services, *Power of Prevention: Reducing the Health and Economic Burden of Chronic Disease*, April 2003.
[6] Ibid.
[7] CDC, Guidelines for School Health Programs to Promote Lifelong Healthy Eating, June 1996, http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm.
[8] Ibid.
[9] U.S. Department of Health and Human Services, *Power of Prevention: Reducing the Health and Economic Burden of Chronic Disease*, April 2003, 3.
[10] CDC, Guidelines for School Health Programs to Promote Lifelong Healthy Eating, June 1996, http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm.
[11] Ibid.
[12] U.S. Department of Health and Human Services, *Power of Prevention: Reducing the Health and Economic Burden of Chronic Disease*, April 2003, 3.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Johnson, Nancy, House Committee on Ways and Means, Hearing on Legislation to Reduce Medical Errors, 107th Congress, 2nd Session, September 10, 2002.
[17] Thompson, Tommy, House Committee on Ways and Means, Hearing on Legislation to Reduce Medical Errors, 107th Congress, 2nd Session, September 10, 2002.
[18] HealthGrades Quality Study: Patient Safety in American Hospitals, July 2004, http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf.
[19] Medical News Today, In Hospital Deaths from Medical Errors at 195,000 per Year in USA, August 9, 2004, http://www.medicalnewstoday.com/printerfriendlynews.php?newsid=11856#.
[20] Hubbard, William, testimony before the Committee on the Judiciary, U.S. Senate, July 14, 2004, http://judiciary.senate.gov/testimony.cfm?id=1264&wit_id=3700.
[21] Owcharenko, Nina, Debunking the Myths of Drug Importation, July 20, 2004, http://www.heritage.org/Research/HealthCare/wm542.cfm?renderforprint=1.
[22] Pilon, Roger, Drug Reimportation: The Free Market Solution, August 4, 2004, 4.
[23] PricewaterhouseCoopers, 1999.
[24] Lewis, Carol, The Impact of Direct-to-Consumer Advertising, March-April 2003, FDA Consumer Magazine.
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Haislmaier, Edmund F., Compromising Quality: The High Cost of Government Drug Purchasing, May 25, 2004, http://www.heritage.org/research/healthcare/bg1764.cfm.
[29] Health Policy Alternatives, Pharmacy Benefit Managers (PBMs): Tools for Managing Drug Benefit Costs, Quality, and Safety, 2003, http://www.pcmanet.org/2004_pdf_downloads/HPA_Study_Final.pdf.
[30] PriceWaterhouseCoopers, The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation, July 2004, http://www.pcmanet.org/keyfindings_pdfs/PricewaterhouseCoopers_Report_Value%20of%20PBMs_Impact_Proposed_LegislationJuly_2004.pdf.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] HHS Approves First-ever Multi-state Purchasing Pools for Medicaid Drug Programs, April 22, 2004, http://www.news-medical.net/print_article.asp?id=766.
[37] Balto, David A., Hatch-Waxman Act: Prospects for Reform, BNA Health Care Policy Report, June 11, 2001, http://www.bna.com.
[38] Ibid.
[39] American Medical Association, Medical Liability Reform – Now!: A Compendium of Facts Supporting Medical Liability Reform and Debunking Arguments Against Reform, June 14, 2004, http://www.ama-assn.org/go/mlrnow (Hereto referred to as AMA).
[40] Ibid.
[41] Ibid.

[42] Ibid.
[43] Wenner, David, Advances Put Strain on Hospitals' Resources, Patriot-News.
[44] U.S. Department of Health and Human Services, Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care, 2003.
[45] AMA, *supra* note 33, at 19.
[46] Ibid.
[47] Ibid.
[48] Congressional Budget Office, Limiting Tort Liability for Medical Malpractice, January 8, 2004, http://www.cbo.gov.
[49] Hunter, Derek, New Data on Health Insurance, the Working Poor, and the Benefits of Health Care Tax Changes, April 28, 2004, http://www.heritage.org/Research/HealthCare/wm492.cfm?renderforprint=1.
[50] Butler, Stuart, Reducing Uninsurance by Reforming Health Insurance in the Small Business Sector, June 17, 2004, http://www.heritage.org/research/bg1769.cfm.
[51] Hunter, *supra* note 43.
[52] Ibid.
[53] Goodman, John C., Health Savings Accounts Will Revolutionize American Health Care, National Center for Policy Analysis, January 15, 2004.
[54] Butler, *supra* note 44.
[55] Scandlen, Greg, Association Health Plans – Part One: Lowering Small Group Costs. National Center for Policy Analysis, October 8, 2002.
[56] Ibid.

U.S. Representative Phil English
1410 Longworth House Office Building
Washington, DC 20515